Section of General Practice

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Problems of an Immigrant Population

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The Immigrant Patient in General Practice

In the contemporary society in which we live the word immigrant is highly emotive. To some it serves as a term of abuse. It is used by all of us as a euphemism for a person whose skin is coloured.

My practice is in a health centre in Shepherds Bush in the London Borough of Hammersmith. Among our patients social classes IV and V predominate, but we also have a higher than average number of classes I and II. It is the artisans, social class III, who are missing. We also have many immigrant patients; indeed only just over half the patients on our list were born in England of English parents. The rest come from all parts of the globe, with a high proportion from Eire and the West Indies.

The age and sex distribution is about the same as that found at the last census for the whole Borough. Among the immigrants, however, young children and their parents (age groups 0–4 and 15–44) are over represented, but we have fewer schoolchildren and grandparents than average.

Much of the housing in the immediate vicinity of the health centre is substandard; 'multiple occupation' is the usual euphemism. In 1961 I studied the housing facilities of my patients. At that time I showed how overcrowded many of them were. Few families were fortunate enough to have a self-contained house of flat. I also showed that immigrants, particularly if they were coloured, had to pay much higher rents for what they got (Carne 1961).

The existence of different culture patterns is a well-recognized sociological phenomenon (Oakley 1968). What we had to learn was how these differences affected the medical needs of immigrants and our delivery of medical care. We, in our practice, have only made a beginning in this direction, but our task is infinitely easier for what we have already learned.

In spite of what we hear and read, we see few exotic tropical diseases in our practice. Worms of various kinds are probably the only common tropical illness we meet. The relative incidence of several of the common diseases is, however, different. We particularly notice the different presentation of illness, the emphasis being placed on different symptoms in different race groups.

The barriers created by language difficulties are an expected medical hazard whenever a doctor has to treat a patient from a different country. What, however, may not always be realized is how people, apparently speaking the same language, use words differently.

Patients frequently come to their doctor with a preconceived idea of what is the matter and of what is likely to happen at the consultation. These conceptions are based on previous experiences, not only of the individual but of his family and his community. The previous medical experiences of immigrants are not usually the same as those of English patients who have had twenty-one years of a National Health Service and generations of mixed private, club and panel practice.

The problems of infertility are of major importance to many of our coloured immigrant patients. For a woman to be barren is for her to have totally failed. She has failed herself and, if she is married, she has failed her husband and his family. The infertility as such may not be presented by the patient and has to be specifically sought by direct questions. What they will present with is depression which we find to be as intractable as its etiology. Most such infertilities are due to chronic pelvic infection.

Table 1
Annual number of consultations per patient (based on those in practice throughout the year)

	All ages	*Age groups*				
		0–4	*5–14*	*15–44*	*45–64*	*65+*
English:						
Male	3·3	5·5	3·3	2·6	3·4	4·5
Female	4·2	5·9	3·4	4·1	4·2	4·1
Irish:						
Male	2·5	5·0	3·4	1·7	3·2	3·1
Female	3·7	4·7	3·9	3·4	4·0	2·2
West Indian:						
Male	3·0	5·3	1·4	2·9	2·2	–
Female	5·3	5·8	3·5	5·5	5·3	–
West African:						
Male	3·1	–	–	3·3	–	–
Female	7·0	3·4	–	6·8	–	–

Tuberculosis is quite rare among West Indians in our part of London. I have, however, seen several cases of florid primary infection among West Indian and Irish children. The radiological picture can be quite alarming in the West Indian child who may have a massive hilar adenopathy.

Chronic bronchitis is practically unheard of in coloured patients though the Irish seem to be as afflicted as the English. This is not surprising when we look at the smoking habits of our immigrant patients. Far fewer coloured immigrants smoke than do English and Irish patients, especially the womenfolk. However, immigrant children get just as much bronchitis as other children and all forms of upper respiratory infection, including otitis media. On the other hand, mothers are less keen on asking for tonsillectomy. Fortunately they have so far failed to acquire this adverse English culture pattern.

Wax in the ears is quite rare in coloured patients; so are varicose veins. But piles, especially in the males, are seen very frequently though the numbers are not significant. Raised blood pressure is a known hazard, particularly in West African patients where it is often associated with chronic pyelitis. Urinary tract infections generally are particularly prevalent among coloured immigrant women. Peptic ulceration is more common in West Indians, and so are all the other digestive upsets.

Table 2
Surgery attendance and house calls (percentage of house calls shown in brackets)

	Total no. of surgery consultations and house calls		
	All ages		*0–14 years*
	Male	*Female*	*Male and female*
English	5,029 (13%)	6,574 (16%)	2,275 (15%)
Irish	1,911 (6%)	2,265 (11%)	1,127 (16%)
West Indian	1,078 (4%)	1,688 (3%)	791 (4%)
West African	329 (2%)	310 (6%)	42 (–)

Headaches of a non-specific type are very common in immigrants. When forced to make a diagnosis we tend to say that these patients are suffering from an anxiety state but, I suspect, they may be suffering from depression. West Africans under stress are liable to suffer a severe schizophrenic illness with, quite often, a most bizarre presentation.

Among the exanthemata we notice an older age incidence among the West Indians than among the English and Irish. Indeed it is not unusual to see an adult with measles, rubella, chicken-pox or mumps.

Iron deficiency anæmias are fairly frequent among West Indian and West African babies and they are also more frequent in Irish than English.

Table 3
Percentage of non-consulters and frequent consulters among patients in the practice for whole year and those who joined during the year

	In practice whole year			*Joined during year*		
	Total No. of patients	*Percentage of consultations*		*Total No. of patients*	*Percentage of consultations*	
		None	*More than 10*		*None*	*More than 10*
English:						
Male	1,326	38	8	136	27	10
Female	1,412	33	11	141	13	16
Irish:						
Male	588	52	6	157	26	5
Female	513	44	11	158	16	11
West Indian:						
Male	273	33	4	77	18	9
Female	258	33	17	89	11	21
West African:						
Male and female	85	41	18	57	22	14

True hæmoglobinopathies are rare, but we do occasionally see sickle-cell anæmias. It is often forgotten that all such patients are likely to collect in a specialist hæmatology clinic giving the pathologist the impression of a case frequency that is quite out of perspective.

The subject of workload looms large in any discussion of the problems of general practice. That too is an emotive word (Carne 1969). Do immigrants give us a lot of extra work? Taking all ages into consideration the answer is 'no'; (Table 1); but we do see the West Indian and West African women more than their English sisters. If, however, we correct for the antenatal attendances there is hardly any difference. Furthermore, the immigrants have fewer house calls than the English, a higher proportion of their consultations being at the surgery.

Table 4
Certificates and prescriptions (age 15–44 only)

	Total no. of consultations	*Percentage with certificate*	*Percentage with prescription*
English:			
Male	1,810	33	54
Female	2,733	14	56
Irish:			
Male	873	36	49
Female	390	17	51
West Indian:			
Male	721	41	49
Female	1,307	27	48
West African:			
Male	308	30	51
Female	339	19	51

Incidentally, it is interesting to see how, at every age, the women consult more than the men. They also have more house calls (Table 2). From infancy through adulthood to the years after retirement the female of the species, English or immigrant, is visited by her doctor more frequently than the male.

But looking at an average consultation rate can be very misleading. We also need to know something about the two extremes: the patients who never consult us and the patients who come more than twice the average. (For convenience we chose to count those who consult us more than ten times in the twelve months.) We also looked at these figures in respect of two distinct groups: patients who were on the list all the year and patients who registered during the twelve months. Patients who newly register usually (though, of course, not always) do so because something is the matter with them or one of their family and they need attention (Table 3).

The proportion of English patients who did not consult at all was midway between the proportion of Irish and of West Indians, and this applied to both the 'all year' and newly registered groups. The largest proportion of frequent attenders was to be found amongst the West Africans (both sexes).

What about paper work in the form of certificates and prescriptions (Table 4)? We found that we issued prescriptions at less of the consultations we had with immigrants than we did with English patients, but we issued certificates more often. With regard to the high proportion of West Indian women taking certificates it should be remembered that a far higher number of them go out to work than English women.

Table 5
Type of certificate (males 15–44 only)

	Total no. of consultations	*Percentage with certificate*			
		Private	*NHS first*	*NHS intermediate*	*NHS final*
English	1,810	18	10	7	9
Irish	873	26	9	9	7
West Indian	721	27	11	11	10
West African	308	15	10	4	9

We looked more closely at the certificates we issued for the men in the 15–44 age group (Table 5). West Indians had proportionately more onset-commencement NHI certificates, and the Irish proportionately less than the English. The West Indians also had more mid-episode certificates than the English, as did the Irish. It does seem that, whatever the reason, West Indian men stay away from work for medical reasons more often and stay away longer.

All patients at the health centre are seen by appointment. By and large, immigrants are as good at keeping appointments as English patients (Carne 1967).

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Immigrants and Emotional Stress

Anxiety caused by inability to adapt oneself in the host community invariably complicates and exaggerates physical illness. The patient may first present himself with aches and pains, hypochondriasis and psychosomatic diseases, or he may show other signs of anxiety and neuroses.

The modern concept of all treatment, not just psychiatric treatment, is a three-dimensional approach with an attempt to deal with physical, social and psychological aspects in any given case. In addition to that it is also essential when working with immigrants to understand the cultural and displacement factors.

The form of mental illness would be the same, whatever the culture. It can be organic or functional, both of which may be acute, sub-acute or chronic. Functional forms can be psychotic, neurotic or psychopathic personality disorders. But the content of mental illness depends on